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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF PRAIRIE VILLAGE	2700 SOMERSET DRIVE PRAIRIE VILLAGE, KS 66206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey and complaint investigation 75481 at the above named assisted living facility conducted on 7-15-14, 7-16-14 and 7-17-14.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3028	Continued From page 1 3028 KAR 26-41-101(f)(3) The facility reported a census of 58 residents. The sample included 3 residents and one closed record review. Based on record review and interview for 1 (#123) of 3 sampled residents and one (#400) closed record review resident, the administrator failed to ensure all allegations of abuse or neglect were reported to the department within 24 hours and an investigation started when the administrator received notification of an alleged violation. Findings included: - Record review for resident #123 revealed admission on 10-25-13 with diagnoses Cerebral Infarction with right hemiplegia, Dementia, Depression, Vitamin B-12 Deficiency and Hyperlipidemia. The functional capacity screen dated 4-21-14 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; independent with eating; and unable to perform management of medications and treatments. Usually continent of bladder. Cognition: problems with short term memory. Current problems/risks included falls and impaired decision-making. The negotiated service agreement dated 4-21-14 stated family member to provide assistance with bathing, dressing, toileting, transfers, and wheelchair mobility. Resident's family member to administer and manage medications. Observation of resident on 7-16-14 at 2:00 pm revealed resident with right sided hemiplegia who stated he/she required assistance with standing	S3028		

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S3028	Continued From page 2 and uses a wheelchair for mobility which someone else has to push. Review of incident reports revealed: 12-28-13 at 6:10 am stated, "Certified staff L walked into apartment to do morning rounds...observed resident sitting on his/her living room floor with his/her wheelchair turned over. Resident was confused and unable to remember what happened, could not say if he/she hit head or not. Did a visual inspection and did not find any head injury visible, nor skin. Eyes were normal and his/her speech was regular pattern. Resident did have a skin tear right elbow that was bandaged. There was not any clutter on the floor in the area he/she fell. Resident was helped back into bed." Signed by certified staff L. Interview on 7-16-14 at 12:10 pm with administrative staff A stated resident's spouse provided care for resident. Spouse fractured ankle in December 2013 and was out of facility for a few weeks, while he/she was gone, facility took over the resident's care. Stated, "he/she fell a lot while he/she was gone." Confirmed the fall on 12-28-13 was unwitnessed, not reported to the department and was not investigated. For resident #123 who required physical assist with transfers and mobility and experienced an unwitnessed fall and was unable to state what had happened, the administrator failed to ensure an allegation of potential abuse or neglect was reported to the department within 24 hours and investigated. - Record review for resident #400 revealed admission on 1-29-13 with diagnoses Anxiety, Frontotemporal Degeneration, High Blood	S3028		

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S3028	Continued From page 3 Pressure, High Cholesterol and Pain. The functional capacity screen dated 4-9-14 recorded resident required physical assistance with bathing, dressing, toileting, and transfers; supervision with walking/mobility and eating; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with short and long term memory, memory/recall and decision-making. Current problems/risks included: impaired decision-making and wandering. The negotiated service agreement (NSA) dated 4-9-14 recorded services for full assistance with bathing, dressing, toileting, transfers; cueing and standby assistance for walking/mobility and cueing/reminders for eating. Facility to manage medications. Staff to provide frequent reminders and redirection as needed. "Incontinence Assistance: Please cue me and take me to the restroom every 2 hours. Use the heat lamp to decrease stimulation while I am in the restroom. I can be incontinent of bladder and bowel at times and will need staff assistacne with cleaning up after those episodes. DO NOT TAKE ME TO THE RESTROOM AND LEAVE ME ON THE TOILET. Stand by my door and provide me privacy but be nearby if there are any needs that arise. Please ensure my skin stays clean and dry and my pull up stays clean and dry..." Nurse's Notes on 5-10-14 at 4:00 pm: "(Certified staff J) reported resident was put on the toilet sometime around the end of the first shift and the dim light turned on by certified staff G. Shift changed and certified staff G went home. it was not reported to certified staff J that resident was still sitting on the pottie. Resident's family	S3028		

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S3028	Continued From page 4	S3028		

member came into room and found him/her sitting on the toilet seat in the dark. Family member was very upset and sweared, got resident up off seat. Saw bright red ring around resident's buttocks that made family member even angrier. He/She took a picture of resident's buttocks and soon after helping him/her dress, came up to him/her and confronted him/her about what happened. Family member then took resident out of facility to go on a car ride. On the way out, family member stopped to talk with activity director about what happened. ----- Some time earlier certified staff G came back and told activity director he/she screwed up big time, explaining leaving resident on the toilet seat and forgetting to tell certified staff J or certified staff K. Activity director stated that he/she told him/her, he/she is human. Certified staff G came back and told him/her that there is a chance he/she may be written up for this. So, when resident's family member came to activity director, he/she was able to tell that certified staff G had come back and was sorry for leaving the way he/she did and returned to explain why it happened. There was no mentioning of this the remainder of the shift." Signed by licensed nurse D.

Interview on 7-16-14 at 12:40 pm with administrative staff A stated he/she had spoken with the family member who "just mentioned it in passing." Confirmed the staff member failed to follow the plan of care as written in the NSA. Further confirmed he/she failed to report this incident to the department and investigate this allegation of neglect.

For resident #400 who experienced neglect when the staff failed to provide services according to the negotiated service agreement, the administrator failed to report the allegation of

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S3028	Continued From page 5 neglect to the department within 24 hours and to start an investigation when notified of the allegation.	S3028		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)(3) The facility reported a census of 58 residents. The sample included 3 residents and one closed record review. Based on record review and interview for 3 (#121, #122, #123) of 3 sampled residents and 1 (#400) of 1 closed record review resident, the administrator failed to ensure the negotiated service agreement contained a description of services the residents would	S3085		

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receive, identification of the provider of each service and identification of each party responsible for payment of the outside provider.

Findings included:

- Record review for resident #121 revealed admission on 1-29-13 with diagnoses Dementia, Osteoarthritis, Hypertension, Hypothyroidism, Vitamin B-12 Deficiency, Osteoporosis and Formal Thought Disorder.

The functional capacity screen (FCS) dated 4-17-14 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating; unable to perform management of medications and treatments. Frequently incontinent of bladder. Cognition: Problems with short and long term memory, memory/recall and decision-making. Current problems/risks identified: falls and impaired decision-making.

The negotiated service agreement (NSA) dated 4-17-14 recorded services for bathing (full assist all aspects), dressing (full assist all aspects), toileting (full assist all aspects), transfers (one person assist all aspects), walking/mobility (wheelchair), eating (cut up meats identify foods, offer finger foods) and facility staff to manage medications and treatments. The NSA lacked documentation of pharmacy provider and each party responsible for payment of the pharmacy provider. The NSA further lacked documentation of interventions to address resident's fall risk.

Record review recorded the following falls:
10-5-13 (no time): "Resident lost balance while walking from shower to bedside. Reported feeling dizzy and fell backwards landing on

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buttocks." Signed by licensed staff D.
10-23-13 (no time): "Resident found sitting on the floor in apartment in the doorway leading to bathroom after hearing a loud crash. Resident stated he/she was trying to get some clothing from the wall wardrobe to wear, fell on his/her back and hit the back of his/her head. Reported pain under bilateral pelvic area then back pain. Observed visible bruises left forearm, lateral left hand and black/blue area above knuckle of first finger, reddened area on knuckle and first finger. Resident stated having hit back of head, we looked at the scalp...and found a slightly red area to the middle back of head." Signed by licensed staff D.
4-14-14 at 7:20 am: "Resident called for help from apartment. Upon entering resident's apartment, could see resident down on the floor in the entryway facing front door laying on left side, body in a half fetal position halfway in front of bathroom with wheelchair in front of his/her foot. Resident asked to get up he/she needed to go to the toilet." Signed by licensed staff D.
4-17-14 at 7:30 am: "Resident found on floor in common kitchen area laying on his/her right side." Signed by licensed staff C.

Interview on 7-15-14 at 2:50 pm with administrative staff A and administrative nurse B confirmed the NSA lacked documentation of interventions to address resident's fall risk and also lacked documentation or resident's pharmacy and identification of the party responsible for paying the pharmacy.

For resident #121 who has a history of falls, the administrator failed to ensure the negotiated service agreement contained interventions to address the resident's fall risk, identification of provider of pharmacy services and identification

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of party responsible for payment of the pharmacy.

- Record review for resident #122 revealed admission on 7-9-14 with diagnoses Hypertension, Osteoarthritis, Depression, Anemia, Hyperlipidemia, Type 2 Diabetes Mellitus, and Alzheimer's.

The functional capacity screen dated 7-7-14 recorded resident required supervision with bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications/treatments. Usually continent of bladder. Current problems/risks included falls.

The negotiated service agreement (NSA) dated 7-7-14 recorded services for bathing (reminders), dressing and facility management of medications. The NSA lacked identification of pharmacy provider and identification of each party responsible for paying the pharmacy.

Interview on 7-15-14 at 4:20 pm with administrative nurse B confirmed the NSA lacked documentation of pharmacy provider and party responsible for paying the pharmacy.

For resident #122 whose medications were managed by the facility, the administrator failed to ensure the negotiated service agreement contained the identification of the pharmacy provider and identification of each party responsible for paying the pharmacy provider.

- Record review for resident #123 revealed admission on 10-25-13 with diagnoses Cerebral Infarction with right hemiplegia, Dementia,

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Depression, Vitamin B-12 Deficiency and Hyperlipidemia.

The functional capacity screen dated 4-21-14 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; independent with eating; and unable to perform management of medications and treatments. Usually continent of bladder. Cognition: problems with short term memory. Current problems/risks included falls and impaired decision-making.

The negotiated service agreement (NSA) dated 4-21-14 stated family member to provide assistance with bathing, dressing, toileting, transfers, and wheelchair mobility. Resident's family member to administer and manage medications. The NSA lacked documentation of a description of therapy services resident received, identification of the home health agency providing therapy services and identification of each party responsible for paying the home health agency.

Record review revealed documentation of a home health agency providing physical therapy services beginning 1-4-14 to 7-1-14 ("Physical Therapy discontinued with goals met").

Interview on 1-16-14 at 11:00 am with administrative nurse A confirmed the home health agency and physical therapy were "not added to the NSA."

For resident #123 who received physical therapy services, the administrator failed to ensure the negotiated service agreement contained a description of the therapy services provided, identification of the home health agency providing

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the therapy and identification of each party responsible for payment of the home health agency.

- Record review for resident #400 revealed admission on 1-29-13 with diagnoses Anxiety, Frontotemporal Degeneration, High Blood Pressure, High Cholesterol and Pain.

The functional capacity screen dated 4-9-14 recorded resident required physical assistance with bathing, dressing, toileting, and transfers; supervision with walking/mobility and eating; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with short and long term memory, memory/recall and decision-making. Current problems/risks included: impaired decision-making and wandering.

The negotiated service agreement (NSA) dated 4-9-14 recorded services for full assistance with all aspects of bathing, dressing, toileting, transfers; cueing and standby assistance for walking/mobility and cueing/reminders for eating. Facility to manage medications. Staff to provide frequent reminders and redirection as needed. The NSA lacked identification of pharmacy provider and identification of each party responsible for paying the pharmacy provider.

Interview on 7-15-14 at 4:20 pm with administrative nurse B confirmed the NSA lacked documentation of pharmacy provider and party responsible for paying the pharmacy.

For resident #400 whose medications were managed by the facility, the administrator failed to

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S3085	Continued From page 11 ensure the negotiated service agreement contained identification of the pharmacy provider and identification of each party responsible for paying the pharmacy provider.	S3085		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 58 residents. The sample included 3 residents and one closed record review. Based on record review and interview for 2 (#121) of 3 sampled residents and 1 (#400) of 1 closed record review resident, the administrator failed to ensure all medications and biologicals were administered in accordance with	S3200		

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a medical care provider's written order and professional standards of practice.

Findings included:

- Record review for resident #121 revealed admission on 1-29-13 with diagnoses Dementia, Osteoarthritis, Hypertension, Hypothyroidism, Vitamin B-12 Deficiency, Osteoporosis and Formal Thought Disorder.

The functional capacity screen (FCS) dated 4-17-14 recorded resident unable to perform management of medications and treatments. The negotiated service agreement (NSA) dated 4-17-14 recorded services for facility staff to manage medications and treatments.

Medication Administration Record for July 2014 revealed documentation of administration of the following medications:
Prednisone 20 mg (milligrams) 2 tablets by mouth daily for 4 days and Tessalon Perles (Benzonatate) 200 mg 1 by mouth three times a day and acetaminophen 500 mg tablets 2 tablets = 1000 mg by mouth daily for pain. The record lacked documentation of written physician's orders for these medications.

Interview on 7-15-14 at 1:04 pm with administrative nurse A confirmed the record lacked documentation of signed physician's orders for the above medications. Stated "we don't do verbal orders. Typically the physician will call the orders directly to the pharmacy and the pharmacy sends the medication out." Administrative nurse A contacted the pharmacy to have them fax the "orders" which also lacked physician signature.

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S3200	Continued From page 13 For resident #121, the administrator failed to ensure all medications and biologicals were administered in accordance with a medical care provider's written order and professional standards of practice. - Record review for resident #400 revealed admission on 1-29-13 with diagnoses Anxiety, Frontotemporal Degeneration, High Blood Pressure, High Cholesterol and Pain. The functional capacity screen (FCS) dated 4-9-14 recorded resident unable to perform management of medications/treatments. The negotiated service agreement (NSA) dated 4-9-14 recorded services for Facility to manage all aspects of medications. Review of Medication Administration Records (MARs) for July 2013 revealed administration of Vitamin D3 5,000 units by mouth daily. August 2013 MAR documented daily administration of Vitamin D 50,000 IU (International Units). Lab report dated 9-6-13 reported Vitamin D level greater than 60 ng/mL (normal range 20-60 ng/ml). Note from physician's office dated 9-11-13 "(physician's nurse) says discontinue vitamin D until level rechecked. Level too high currently." Interview on 7-16-14 at 1:30 pm with administrative nurse A stated the facility switched pharmacies around the end of July 2013...the new pharmacy made an error on the physician's order sheet and began sending Vitamin D 50,000 IU instead of 5,000 units. Confirmed the resident received the wrong dose of Vitamin D during August. The Vitamin D was ultimately discontinued by the physician.	S3200		

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S3200	Continued From page 14 Physician's order dated 12-26-13: Diflucan Tablet 150 mg (milligrams) orally. Dispense 3 tablets. 1 tablet one every 3 days 3 days. Signed by physician. Review of MAR for December 2013 revealed documentation of administration of Diflucan 150 mg tablet at 9:00 am on 12-27-13, 12-28-13 and 12-29-13. Interview on 7-16-14 at 1:30 pm with administrative nurse A reviewed the order and stated he/she didn't "know what the order meant"; the order should have been clarified with the physician as to whether to administer 1 tablet every 3 days for 3 doses or 1 tablet for 3 days in a row. Confirmed the physician was not contacted for clarification. For resident #400, the administrator failed to ensure all medications and biologicals were administered in accordance with the physician's written order and professional standards of practice.	S3200		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract	S3248		

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S3248	Continued From page 15 staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d) The facility reported a census of 58 residents. The sample included 3 residents and one closed record review. Based on record review and interview for 3 (certified staff G, H and I) of 5 sampled employee records, the administrator failed to ensure the employee records contained evidence of certification for each employee performing a function that requires specialized education or training. Findings included: - Review of personnel records revealed the following: Certified staff G date of hire 12-6-13: nurse aide registry contacted 2-20-14 to confirm certification. Certified staff H date of hire 11-25-13: nurse aide registry contacted 2-20-14 to confirm certification.	S3248		

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S3248	Continued From page 16 Certified staff I date of hire 3-14-14: record lacked documentation of certification. Interview on 7-15-14 at 2:00 pm with administrative staff A confirmed record for certified staff I lacked documentation of certification and records for certified staff G and H records lacked documentation of the registry being checked on or before date of hire. For certified staff G, H, and I, the administrator failed to ensure the employee records contained evidence of certification for each employee performing a function that requires specialized education or training.	S3248		
S3261 SS=F	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: 3261 KAR 26-41-105(f)(11) The facility reported a census of 58 residents. The sample included 3 residents and one closed record review. Based on observation, record review and interview for 2 (#121, #122, #123) of 3 sampled residents and one (#400) closed record review resident, the administrator failed to ensure documentation of all incidents, symptoms and other indications of illness or injury including date,	S3261		

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time of occurrence, action taken and results of the action.

Findings included:

- Record review for resident #121 revealed admission on 1-29-13 with diagnoses Dementia, Osteoarthritis, Hypertension, Hypothyroidism, Vitamin B-12 Deficiency, Osteoporosis and Formal Thought Disorder.

The functional capacity screen (FCS) dated 4-17-14 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and eating; unable to perform management of medications and treatments. Frequently incontinent of bladder. Cognition: Problems with short and long term memory, memory/recall and decision-making. Current problems/risks identified: falls and impaired decision-making.

The negotiated service agreement (NSA) dated 4-17-14 recorded services for bathing, dressing, toileting, transfers, walking/mobility, eating and facility staff to manage medications and treatments.

Review of nurses notes for 7-7-14 stated: "Message left for physician...resident complained of chest congestion, cough. Resident's family member also brought to the nurse's attention this past weekend that resident has asthma, this was the first time we were told of this. Vital signs recorded. Oxygen saturation 91% at rest. Call placed to physician for advice." Signed by licensed staff D. The record lacked documentation of nursing assessment and any followup with physician.

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S3261	Continued From page 18 Observation on 7-15-14 at 2:17 pm revealed resident sitting in wheelchair with blanket wrapped around his/her shoulders and participating with other residents in a reminiscence game in common area of memory care unit. Interview on 7-15-14 at 2:43 pm with administrative nurse B confirmed the record lacked documentation of assessment and followup with physician. For resident #121, the administrator failed to ensure documentation of nursing assessment and followup with physician when the resident experienced respiratory symptoms. - Record review for resident #122 revealed admission on 7-9-14 with diagnoses Hypertension, Osteoarthritis, Depression, Anemia, Hyperlipidemia, Type 2 Diabetes Mellitus, and Alzheimer's. The functional capacity screen dated 7-7-14 recorded resident required supervision with bathing and dressing; independent with toileting, transfers, walking/mobility and eating; and unable to perform management of medications/treatments. Usually continent of bladder. Current problems/risks included falls. The negotiated service agreement dated 7-7-14 recorded services for bathing, dressing and facility management of medications. Record lacked documentation of resident's arrival (date/time) including initial assessment and adjustment to facility.	S3261		

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Interview on 7-15-14 at 3:40 pm with administrative nurse B confirmed the record lacked documentation of nursing admit note, assessment and indications of how resident was adjusting. Licensed Staff D wrote a late entry admission note after the record was requested.

For resident #122, the administrator failed to ensure documentation of admission including an initial nursing assessment.

- Record review for resident #123 revealed admission on 10-25-13 with diagnoses Cerebral Infarction with right hemiplegia, Dementia, Depression, Vitamin B-12 Deficiency and Hyperlipidemia.

The functional capacity screen dated 4-21-14 recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility; independent with eating; and unable to perform management of medications and treatments. Usually continent of bladder. Cognition: problems with short term memory. Current problems/risks included falls and impaired decision-making.

The negotiated service agreement dated 4-21-14 stated family member to provide assistance with bathing, dressing, toileting, transfers, and wheelchair mobility. Resident's family member to administer and manage medications.

Observation of resident on 7-16-14 at 2:00 pm revealed resident with right sided hemiplegia who stated he/she required assistance with standing and uses a wheelchair for mobility which someone else has to push.

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Review of incident reports revealed: 12-28-13 at 6:10 am stated, "Certified staff L walked into apartment to do morning rounds...observed resident sitting on his/her living room floor with his/her wheelchair turned over. Resident was confused and unable to remember what happened, could not say if he/she hit head or not. Did a visual inspection and did not find any head injury visible, nor skin. Eyes were normal and his/her speech was regular pattern. Resident did have a skin tear right elbow that was bandaged. There was not any clutter on the floor in the area he/she fell. Resident was helped back into bed." Signed by certified staff L.

Review of nurse's notes revealed documentation for falls on 11-1-13, 12-18-13 (2 falls), 12-22-13, 12-31-13 and 2-26-14. The record lacked documentation of the unwitnessed fall on 12-28-13 at 6:10 am.

Interview on 7-16-14 at 12:10 pm with administrative staff A confirmed the fall was not documented in the resident's record.

For resident #123, the administrator failed to ensure documentation of all incidents when the resident experienced an unwitnessed fall on 12-28-13.

- Record review for resident #400 revealed admission on 1-29-13 with diagnoses Anxiety, Frontotemporal Degeneration, High Blood Pressure, High Cholesterol and Pain.

The functional capacity screen dated 4-9-14 recorded resident required physical assistance with bathing, dressing, toileting, and transfers; supervision with walking/mobility and eating; and

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unable to perform management of medications/treatments. Occasionally incontinent of bladder. Cognition: problems with short and long term memory, memory/recall and decision-making. Current problems/risks included: impaired decision-making and wandering.

The negotiated service agreement dated 4-9-14 recorded services for full assistance with bathing, dressing, toileting, transfers; cueing and standby assistance for walking/mobility and cueing/reminders for eating. Facility to manage medications. Staff to provide frequent reminders and redirection as needed.

Nurse's notes date 6-3-14 stated: "Staff reported that resident's family stated that resident was holding his/her hands in fist and fingers on bilateral hands turned blue when fingers were released. Family member stated that he/she was advised by physician if this ever happened, resident was to be taken to the emergency room for evaluation. However, family member said the pink color returned to fingers, he;she took resident for evaluation. Family member called at about 9:18 pm to report he/she was about to leave the hospital emergency room and was on the way back to facility with the resident. Family member asked that resident's vital signs be monitored throughout the night. Family member called back some time later and reported that he/she stopped by home to check on his/her dogs and had decided to have resident stay at home for the night." Signed by licensed staff D. The nurse's notes lacked further documentation until discharge note written on 6-27-14.

The record lacked documentation of resident's return to the facility and followup nursing

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S3261	Continued From page 22 assessment. Interview on 7-15-14 at 1:30 pm with administrative nurse B confirmed the record lacked documentation of resident's return to the facility including assessment and followup with physician. For resident #400, the administrator failed to ensure documentation of resident's return to facility after visit to emergency room including a nursing assessment and followup with physician.	S3261		
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(d)	S3298		

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S3298	Continued From page 23 The facility reported a census of 58 residents. The sample included 3 residents and one closed record review. Based on record review and interview for all residents receiving dietary services, the administrator failed to ensure food was prepared using safe methods that conserved the nutritive value, flavor, and appearance and was served at the proper temperature. Findings included: - Review on 7-16-14 at 12:35 pm of Food Temperature Logs for July 2014 revealed the logs lacked documentation of temperatures on the following dates for the indicated meals: 7-1-14 (dinner); 7-3-14 (breakfast); 7-4-14 (breakfast, lunch, dinner); 7-5-14 (dinner); 7-6-14 (breakfast, lunch, dinner); 7-7-14 (breakfast, dinner); 7-8-14 (breakfast, lunch, dinner); 7-9-14 (dinner); 7-11-14 (breakfast); 7-12-14 (breakfast, lunch, dinner); 7-13-14 (breakfast, dinner); and 7-14-13 (breakfast, dinner). Interview on 7-16-14 at 12:35 pm with dietary administrative staff F confirmed the logs lacked documentation of food temperatures on the above dates for the indicated meals. For all residents receiving dietary services, the administrator failed to ensure food was prepared and served at the proper temperature.	S3298		
S3420 SS=E	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems.	S3420		

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S3420	Continued From page 24 (A) The system shall be designed to maintain a year-round indoor temperature range of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by:	S3420		

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S3420	Continued From page 25 KAR 28-39-256(c)(2)((B) The facility reported a census of 58 residents. The sample included 3 residents and one closed record review. Based on observation and interview for one of two public restrooms on the assisted living side, the administrator failed to ensure the temperature of hot water ranged between 98 degrees Fahrenheit and 120 degrees Fahrenheit at bathing facilities, sinks and lavatories in resident use areas. Findings included: - Observation on 7-15-14 at 10:15 am with Maintenance Director revealed public restroom next to kitchen with a hot water temperature of 135.5 degrees Fahrenheit. Interview on 7-15-14 at 10:15 am with Maintenance Director confirmed the above temperature. Recheck of temperature on 7-15-14 at 3:45 pm revealed 132.0 degrees Fahrenheit. Interview on 7-15-14 at 4:00 pm with maintenance director confirmed the above temperature and made adjustments underneath the sink. Recheck of water temperature revealed 109.5 degrees Fahrenheit. For one of two public restrooms in assisted living, the adminsitrator failed to ensure the temperature of hot water ranged between 98 degrees Fahrenheit and 120 degrees Fahrenheit at bathing facilities, sinks and lavatories in resident use areas.	S3420		